

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. **31466**

Registration District No. **85**

Primary Registration District No. **1001**

Registrar's No. **1028**

1. PLACE OF DEATH:

(a) County **Buchanan**
(b) City or town **Saint Joseph**
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
2636 Olive Street
(If not in hospital or institution, write street number or location) **3**
(d) Length of stay: In hospital or institution _____ (Specify whether)
In this community **14 months**
years, months or days

2. USUAL RESIDENCE OF DECEASED:

(a) State **Iowa** (b) County **Boone**
(c) City or town **Ogden, Iowa**
(If outside city or town limits, write "RURAL")
(d) Street No. _____ (If rural, give location)
(e) If foreign born, how long in U. S. A.? _____ years.

3. (a) PRINT FULL NAME **Mrs. Margaret Richie Anderson**

3. (b) If veteran, name war **None** 3. (c) Social Security No. **NONE**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, widowed, married, divorced **Widow**

6. (b) Name of husband or wife **William Anderson** 6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased **June 9 1857**
(Month) (Day) (Year)

8. AGE:	Years	Months	Days	If less than one day
	83	3	10	hr. _____ min.

9. Birthplace **Ardrie, Scotland**
(City, town, or county) (State or foreign country)

10. Usual occupation **Housewife**

11. Industry or business _____

12. Name **James Murray**

13. Birthplace **Unknown, Scotland**
(City, town, or county) (State or foreign country)

14. Maiden name **Agnes Richie**

15. Birthplace **Unknown, Scotland**
(City, town, or county) (State or foreign country)

16. (a) Informant **Mrs. Agnes Neff**

(b) Address **2636 Olive Street**

17. (a) **Removal** (b) Date thereof **Sept. 22, 1940**
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation **Ogden, Iowa**

18. (a) Signature of funeral director **Mrs. E. R. Silenfadu**
(b) Address **602 South 10th Street**

19. (a) **9/23/40** (b) **A. F. Meek**
(Date received local registrar) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month **Sept** day **19**
year **1940** hour **5** minute **40 A.M.**

21. I hereby certify that I attended the deceased from **Aug 28**, 19**40**, to **Sept 19**, 19**40**, that I last saw her alive on **Aug. 28**, 19**40**, and that death occurred on the date and hour stated above.

Immediate cause of death **Cardio-Vascular Panel Disease**
Due to **Atherosclerosis**

Other conditions (Include pregnancy within 3 months of death) **121**

Major findings: **no operations**
Of operations _____
Of autopsy **no autopsy**

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) _____
(b) Date of occurrence _____
(c) Where did injury occur? _____ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? **85**

23. Signature **Gordon D. Wright, M.D.** (M. D. or other) **W**
Address **845 So 19th St, Iowa** Date signed **9/21/40**

Duration **not determined**
not determined
PHYSICIAN
Underline the cause to which death should be charged statistically.

WRITE PLAINLY—USE UNFADING, BLACK INK—MAKE A PERMANENT RECORD

MOTHER FATHER

Dr. Wright

Labor Church

STATEMENT BY LICENSED EMBALMER.

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____

Mollie E. Sidenfaden

Registered Apprentice No. 145

working under my personal supervision.

Signed

R. V. Kerst

Licensed Embalmer No. 3876

P. O. Address St Joseph Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.